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during the period of convalescence the patient was strongly prone to localize events in time according to their vividness in her memory, indicating weakness of associative processes. The high degree of apathy shown by the patient in the lower stages of her mental obnubilation seems to have been due in part to the general exhaustion which weakened memory also, and also in part to the loss of the stimulus that a regular supply of memory images furnishes. This patient had so much better memory for auditory than for visual images in youth that the period of their return was separated by a marked interval. Loss of memory is so commonly associated with unrecoverable cases, or the restoration of memory, if it occurs, is too sudden to afford opportunity to study its stages, so that altogether this must be called a noteworthy case.

*Illustrations of Unconscious Memory in Disease, including a Theory of Alternatives.* By CHARLES CREIGHTON, M. D. London, 1886.

This book is a remarkable illustration of interpreting the physiological by the psychological, rather than the reverse, as is more often done, and seems to have been suggested by Hering's lecture on "Memory as a Function of Organized Matter," and by Hartmann's "Unconscious." Consciousness on the one hand and generation on the other represent the extremes of explicit and of implicit memory. Generation is potential, consciousness actual, memory. Every lapse from or retreat behind consciousness represents the tendency to involution toward the above acme of implicitness. Repairs and growth, especially of new tissue after traumatism, are a reminiscence of embryonic activity. The memory of development is concentrated in the ovaries, and ovarian tumors are fantastic and perverted productions. Reproduction is the deepest rooted memory. All diseases, in fact all reminiscences, perverted or not, is of earlier states or experiences of the individual or ancestral organism. A neurotic person, *e. g.*, has a retentive memory. Alternatives are means of habit-breaking. Does not the instinctive doubt which arises as to the soundness of Dr. Creighton's method imply a deep-seated distrust in the normative nature of consciousness?

*Remarkable Case of Sudden Loss of Memory.* F. P. DAVIES, M. D. (England). *Am. Journal of Insanity*, April, 1887.

A young man of 22 was brought to an English asylum in July, 1886, who had apparently lost all memory of his own name, friends, or past life. He habitually wore a puzzled look, and spent much time in trying to recall his past life. After a few days he began to have "inspiration." The name of a person he knew came back or was "revealed" to him, and later another; but both these persons when written to denied all knowledge of the man described. He became depressed, and wrote intelligent letters indicating much mental culture, to others, describing himself, but compelled to subscribe himself as "Unknown." His photograph was taken and sent in vain. After about four months it was half believed that he was malingering, and he was put into an unpleasant ward and told he should not leave it till he had ended his game and told his name and address. The next day these came back to him and he wrote letters to his friends and was taken away. His memory now returned rather rapidly. The author was convinced that the loss of memory was genuine, and that it came on during two days of helpless

wandering in an abnormal state in which he was first found by the police. He proved to have been a clerk of ability in a large establishment which he had suddenly left because a demand for more salary was refused, and had disappeared. Was it epilepsy?

*Habit in Insanity.* By A. B. RICHARDSON, M. D. Am. Journal of Insanity, April, 1887.

The three elements determining habitual discharge of nervous energy are (a) congenital disposition; (b) experience under external conditions; (c) inhibitory and directory power over the will. The latter two can be to a degree controlled. Disease especially, however, weakens the will, and the insane are more imitative than the sane. In the early stages of disease bad habits can be best modified for the better. Even delusions which are often very fixed may be removed or replaced by others less incurable, not by argument, but by environment and treatment. Fixed habits of treatment by physicians are responsible for many bad habits of patients. Habits of taking certain drugs, habits of filth and untidiness, laziness, destructiveness, and even homicidal propensities, may be greatly modified for the better by persevering adaptation of treatment to individual cases, remembering that "our nervous system grows to the modes in which it is exercised." Love of this adaptation and individual study is the best guarantee that a physician is growing in excellence. The writer has tried his method with great success in his own asylum. The patient must be always placed in a position most favorable to reassume sane habits.

*Lecture on the Disorders of Language.* By PROFESSOR BIANCHI, Naples. Alienist and Neurologist, April, 1887.

This article, translated by Dr. Joseph Workman, of Toronto, the well known and still vigorous octogenarian alienist, represents that the four elementary factors of speech (two sensory—hearing and seeing—and two motor—speaking and writing) which have been developed and inter-related in the evolution of speech, connect with functional extrinsication of diverse parts of the brain; writing and reading being of course much later ontogenetically and philogenetically than hearing and speaking. Hearing is located on the first temporal convolution and a part of the second; seeing words in the inferior parietal lobule; speaking in the foot of the left inferior frontal convolution, and writing at the foot of the left second frontal convolution. Each centre is situated within larger related areas, the motor in the wider field of arm or tongue and jaw motions, and the sensory are specialized centres within the field of hearing and sight; and these special as well as the wider general centres are very closely related, so that a disease of one without an affection of others is rare. Each centre, too, is the focus of memory images. Thus one may hear but not know the meaning of words, as is the case with a child. This is the sensory aphasia of Wernicke, or the verbal deafness of Kussmaul, and is often associated with paraphasia. Lichtheim's view that the inner acoustic image, or internal diction, is indispensable to correct pronunciation is refuted by clinical facts. His theory that simple verbal deafness is due to lesion of the centripetal auditive paths before their entrance into the centre, it being sound, is opposed to that of Charcot and Kussmaul, that this may be due to lesion in the acoustic centre, while speaking, reading